DISCUSSION OF PAPER BY CARROLL L. WITTEN: PUBLIC-PRIVATE PARTNERSHIP: ITS IMPACT UPON PHYSICIANS AND THEIR PROFESSIONAL ASSOCIATES*

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CARROLL Witten is an experienced and sophisticated representative of the practicing private physicians, and John Cashman is an equally wise veteran of the governmental wars. They are both, of course, right in their commentaries. The public-private partnership is neither working nor unworkable. Both the problems and the promises need reexamination.

The primary need is for balance or, better, for reciprocity in the partnership. With increasing use of tax funds for medical care must come more public responsibility on the part of each spending agency. With more operational authority in the hands of providers must come more effective representation by the users of health services. With "usual, customary, or reasonable" rates of reimbursement to physicians and other professionals must come proper controls over the efficiency and the quality of their performance. And so on, in a long array of necessary balances.

Some of this, of course, has already been achieved; more is developing as the public-private partnership so rapidly expands; but the gaps still abound and compel more critical attention.

At this moment in time, in my opinion, the medical profession is having a greater influence on the public agencies than is true of the reverse of this relation. A sweater, I am informed, can be defined as something a child puts on when his mother is cold. Similarly, the medical care system—public and private—in the United States today is

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determined largely by professional concepts of how service ought to be arranged. Thus Medicare becomes a sieve through which huge sums of federal monies pour into the medical market place; the Regional Medical Program is used as a new source of support for postgraduate medical education and for categorical research; the health-center concept is neatly contained within the slums that lack doctors, and comprehensive planning for health emerges essentially stillborn—perhaps from overzealous prenatal anesthesia.

Actually I am increasingly convinced—despite my own previous writings and agitations on the subject—that the ultimate effectiveness of medical care from the patient's point of view is *not* directly determined by any high-level financial or organizational medical-care system which fails to include specific and conscious efforts to reconstruct with first priority the bottom or primary level of care. In every country of the world that I have visited—not excluding those most acclaimed as having the highest forms of social organization in this field—an elaborate and complex superstructure of specialty and hospital care rests, always precariously, upon the filmsy underpinning of threadbare and often isolated services of general practitioners. This remains true in Great Britain, Sweden, Czechoslovakia, and, most certainly, in our own country—despite the affluence or sophisticated social organization which these nations represent. Perhaps more of the hope of the future is to be found in the less spectacular but more strongly decentralized systems such as those of Norway and Yugoslavia. The inverted pyramid of organized health service needs badly to be set back on its proper base if any lasting stability is to achieved.

The matter of balance between local participation and public accountability also needs a careful second look. In recent years the traditional pattern of federal-state-local funding and programming has been largely replaced in the United States by a new pathway which goes directly from federal agency to regional and community nongovernmental outlets. Thus Medicare works through its private or nonprofit "fiscal intermediaries"; funds of the Regional Medical Program are allocated to ad hoc consortia led usually by universities; neighborhood-health-center projects of the Office of Economic Opportunity are managed by groups of local citizens; Model Cities projects are similarly illustrative of federal-local grant mechanisms; etc. Each of these bypass the formal state and city authorities. Such wholly new federal policies,

on the one hand, do enhance local participation and program flexibility but, on the other hand, they raise the issues of public accountability for public funds. The needed balance in this developing new partnership depends directly upon the adequate resolution of these issues.

But mostly our people need health services—public or private—and not more tedious documentation or repetitious conferences. We have had decades of such substitutes for action: surveys in the 1940's, commissions in the 1950's, and now, in the 1960's, planning is the *in* thing. But we have now long understood the basic concepts necessary for the development of programs for the provision of health services—knowledge enough to support many years of action efforts. I submit that such program experience, constantly assessed through careful evaluation research, is the only effective stimulus for improvements in our current theory and thus for subsequent modifications in our system of health care. The essential unity of theory and action lies at the very heart of this matter of balance in medical care.

We are, in my opinion, quite ready for such direct action. With respect to the over-all national picture (and it must be emphasized that the points that follow do not hold true for local areas or for particular segments of the whole) we do not *necessarily* need more dollars nor more physicians nor—and of this I remain quite certain—more insuring agencies. The nearly 60 billions of dollars, the 1:800 or so ratio of physicians to population, and the hundreds of fiscal middlemen may now be sufficient as a general base for vastly improved national health services—*if* they are deployed and coordinated in ways which would make such resources optimally useful. The key for this lies in a reorganization from the bottom of the structure and function of medical care. This, in turn, means the full exploitation of knowledge already developed in such areas as health teamwork in local health centers closely affiliated "vertically" with supporting specialty and hospital resources and coordinated "horizontally" with nursing homes, home-care services, and similar facilities for the full spectrum of long-term care—always with the strongest possible involvement of the local community of users.

Only thus can the pyramid be stood again on its base and only through such conscious rationalization of our current resources can we learn accurately whether or not our billions of dollars, our hundreds of thousands of health professionals, and our bevies of insuring

agencies are sufficient or not. Then the inevitable role of government in administration and financing, and the essential role of the health professions in the provision of service can find the harmony or the balance which we initially set out to discover.

I have few doubts regarding our ability ultimately to achieve such logical application of our enormous resources, especially as my experience deepens in association with the exciting new generation of students in the health sciences. This optimism strains, however, to break through the disquiet which I have felt increasingly in recent months over the seeming unwillingness of my colleagues in health affairs to take leadership in the demand for the creation of a national social policy which would permit such rational and, indeed, obvious medical-care programming to take place. As always in history, the issue takes something of the form of the young against the old and the unsatisfied against the complacent. We can only stand with Mort Saul, peering myopically around us, remembering that "the future lies ahead"!